Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 6, 20, 2018	2018_538144_0019	012484-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Southwood Lakes
1255 North Talbot Road WINDSOR ON N9G 3A4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CAROLEE MILLINER (144), CASSANDRA TAYLOR (725), HELENE DESABRAIS (615), NANCY SINCLAIR (537), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 18, 19, 20, 21, 22, 25, 26, 27, 28, and 29, 2018.

The following inquiries were completed on site during the RQI:
Log #026549-17, IL-54188-LO related to major equipment breakdown
Log #024155-17, CI 2842-000019-17 related to prevention of abuse and neglect and responsive behaviours.

The following complaint reports were inspected during the RQI:
Log #007979-17, IL-50428-LO related to responsive behaviours and reporting and complaints
Log #009366-18, IL-56847-LO related to responsive behaviours and falls prevention and management
Log #008074-17, IL-50450-LO related to residents' bill of rights
Log #025138-17, IL-53831-LO related to prevention of abuse and neglect and responsive behaviours
Log #010388-18, IL-57006-LO related to falls prevention and management and bedtime and rest routines
Log #009769-18, IL-56924-LO related to residents' drug regime
Log #011514-18, IL-57157-LO related to responsive behaviours, protection from certain restraining, prevention of abuse and neglect, residents' drug regime and behaviours and altercations
Log #012878-18, IL-57348-LO related to responsive behaivours, falls prevention and management program, communication and response system, and prevention of abuse and neglect

The following critical incident system reports (CIS) were inspected during the RQI:
Intake #021546-17, CIS #2842-000018-17 related to preventions of abuse and neglect
Intake 024861-17, CIS #2842-000023-17 related to prevention of abuse and neglect and responsive behaviours
Intake 001268-18, CIS #2842-000001-18 related to prevention of abuse and neglect and responsive behaivours
Intake #032776-16, CIS #2842-000015-16 related to prevention of abuse and neglect
Log #020119-16, CIS #2842-000006-16 related to duty to protect
Log #024328-17, CIS #2842-000021-17 related to prevention of abuse and neglect and responsive behaviours
Log #020209-17, CIS #2842-000016-17 related to duty to protect, altercations and other interactions between residents
Log #017793-16, CIS #2842-000004-16 related to duty to protect
Log #007818-17, CIS #2842-000008-17 related to duty to protect
Log #017738-17, CIS #2842-000013-17 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with more than twenty residents, Residents' Council representative, more than three family members, the Administrator, Acting Director of Care, Social Worker, Reception Clerk, Office

Manager, one maintenance personnel, one Registered Nurse, seven Registered Practical Nurses, six Personal Support Workers, two Health Care Aides, one Resident Program Aide and one contracted employee.

During the course of the inspection, the inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, medication rooms, medication administration and medication count, the provision of resident care, recreational activities, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records, relevant policies and procedures and the posting of required information.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means,
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("mauvais traitement d'ordre sexuel").

A CI was submitted to the Ministry of Health and Long-Term Care (MOHLTC) describing an incident of resident to resident abuse.

Review of one resident progress notes stated that the resident was observed by a Personal Support Worker (PSW) inappropriately touching another resident.

The CIS report included documentation that an investigation took place and the home determined that the incident occurred.

A second CI submitted to the MOHLTC, described an incident of resident to resident abuse.

The progress notes for the resident identified in the second CI report stated that the resident was seen by a PSW acting both verbally and physically inappropriate with another resident.

The CIS report included documentation that an investigation took place and the home determined that the incident occurred.

The Acting Director of Care (ADOC) acknowledged that the incidents described in both CI reports met the definition of sexual abuse. [s. 19. (1)]

2. A complaint submitted by the family of one resident indicated that the resident had been abused by a another resident at the home and that the abuse had occurred multiple times.

A review of six CIS reports submitted to the MOHLTC revealed multiple incidents related to the responsive behaviours of one identified resident toward residents in the home related to inappropriate touching.

On interview, one Registered Practical Nurse (RN), one Health Care Aide (HCA) and the Recreation Programs Aide shared they had an awareness of the known inappropriate behaviours of one resident and the interventions in place for management of the behaviours.

One Behavioural Supports Ontario Registered Practical Nurse (BSO/RPN) told Inspector #537 that the identified resident had been under the services of the home's internal and external specialized teams and, that monitoring of the resident continued.

One BSO/RPN stated that various interventions to manage the behaviours of the resident had been put into place by one of the home's specialized teams.

The ADOC stated that the resident had known inappropriate behaviours with other residents, that specific interventions had been an effective means of managing the behaviours.

The ADOC stated that there were no plans to stop the specific interventions as it was believed that the resident would exhibit the behaviours again if not observed and, the specific interventions have ensured the resident did not have opportunity to approach other residents.

The ADOC stated that despite referrals and behaviour interventions, the home was not able to protect identified residents from abuse by this resident. [s. 19. (1)]

3. A third CI report was submitted to the MOHLTC describing an incident of resident to resident abuse involving two residents.

Review of progress notes for one resident stated that the resident had been inappropriate toward another resident.

The ADOC acknowledged that the incident between the two residents met the definition of abuse.

The licensee has failed to ensure that resident #023 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Section 2 (1) of Ontario Regulation 79/10 defined sexual abuse as "any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

One identified resident had known inappropriate behaviours towards other residents, as indicated by the home's submission of seven CIS reports to the MOHLTC.

The CIS reports related to the inappropriate responsive behaviours of the above identified resident toward residents in the home.

Twelve Point Click Care (PCC) progress notes reviewed for the resident from the date of the initial CIS report submitted by the home to the present date, included documentation describing inappropriate responsive behaviours toward other residents.

Review of the clinical record for the resident included a written care plan focus and interventions to manage the residents' inappropriate behaviours toward other residents.

The clinical record for the resident included written documentation of involvement by the home's internal and external specialized teams.

One Health Care Aide (HCA) told Inspector #537 they were aware of the known behaviours of the resident and stated that if they were to observe anything that might be considered to be inappropriate behaviour toward another resident, they would report immediately to their Team Lead.

One Registered Practical Nurse (RPN) told Inspector #537 they were aware of the known inappropriate behaviours of the identifed resident and that any actions by the resident that might be of an inappropriate nature would be required to be reported and they would be report to the Charge Nurse who would then follow up with management.

One Recreation Programs Aide shared they were aware of the known inappropriate behaviours of the resident and the interventions in place for management of the behaviours. The Recreation Programs Aide shared that if they were to observe the resident engage in anything that might be considered to be inappropriate toward another resident, they would report to their manager.

Inspector #537 reviewed the seven CIS reports with the ADOC.

Inspector #537 reviewed the PCC progress notes with the ADOC involving the identified resident.

The ADOC stated that the responsive behaviours of the resident were well known to staff, that the CIS reports were filed as the resident had actually touched other residents inappropriately.

The ADOC stated that despite the known history of the resident, the inappropriate behaviours reviewed in PCC by the Inspector, the specialized team supports involvement & medical interventions, the incidents of interaction of the resident as noted in the PCC progress notes with other residents were not reasonable grounds to warrant reporting as abuse of a resident to the MOHLTC.

The licensee failed to report immediately to the Director, when there was suspicion of or reasonable grounds to suspect that sexual abuse of a resident had occurred. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no staff at the home performed their responsibilities before receiving training in the following areas:
The Residents' Bill of Rights
The long-term care home's mission statement
The long-term care home's policy to promote zero tolerance of abuse and neglect of residents
The duty under section 24 to make mandatory reports
The protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; and infection prevention and control.

Long-Term Care Homes Act (LTCHA), 2007, c. 8, s.1(2) defines staff, in relation to a long-term care home, to mean a person who work at the home, pursuant to a contract or agreement between the licensee and an employment agency or other third party.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect– RC-02-01-01"

last updated April 2016, stated in part:
Orient all new staff, volunteers, students, agency/contractors and other relevant persons to all the policies supporting the Zero Tolerance for Abuse and Neglect program.

At minimum, the following information will be available:
Definitions of resident abuse/neglect and how to recognize and report it; Consequences for abusing/neglecting a residents or failing to report it
Whistleblower protection
How to identify and manage signs and symptoms of caregiver burnout
Strategies to promote trusting relationships, mitigate power imbalances and prevent situations that may lead to abuse or neglect
Strategies to prevent resident to resident abuse including ways to manage responsive behaviours
Extendicare Commitment to Residents; Resident rights
Least restraining policy and use of personal assistive devices
Complaint procedures; Relevant regulation.

During the RQI, Inspector #537 observed a one-on-one caregiver seated in a chair in the room of one identified resident.

The resident was observed to be in the room.

The one-on-one caregiver told Inspector #537 the name of the agency that they worked for, that they did not provide any care and that they were there to observe the resident.

The one-on-one caregiver told Inspector #537 that if the resident required any assistance that they would call for staff from the home.

The one-on-one caregiver told Inspector #537 that they had not received any training from the home as a one-on-one caregiver and when asked specifically, stated the only training they had received regarding abuse had been provided by the agency they were employed by.

The ADOC stated that the home contracted caregivers from two agencies and that contracted staff who provided one-on-one care did not provide personal care and did not require training.

The ADOC stated that training had not been provided to any of the contracted workers

who functioned as one-on-one caregivers to residents in the home.

The ADOC acknowledged that per the home policy and the Long Term Care Home Act (LTCHA), all contracted employees required training despite their roles within the home.

The licensee failed to ensure that one-on-one caregiver #123 and all contracted caregivers were trained in all required areas prior to performing responsibilities within the home. [s. 76. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no staff at the home performed their responsibilities before receiving training in the following areas: the Residents' Bill of Rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; and infection prevention and control, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences, at least once in every calendar year.

The ADOC provided a copy of the 2017 annual evaluation of the home's Resident Abuse and Neglect program. The form had not been completed, and did not include any information.

The ADOC showed Inspector #537 a completed evaluation with a documented date but was not able to provide any documentation that the program had been evaluated since this date.

The ADOC consulted with the Social Worker who confirmed that the program had not been evaluated since January 30, 2016, and that an evaluation had not been completed in 2017 as required.

The licensee failed to complete an evaluation of the licensee's policy to promote zero tolerance at least once in every calendar year. [s. 99. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences, at least once in every calendar year, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

One resident was identified to have a medication order for a controlled substance.

During review of medication error incidents it was identified that on one specific date, an RPN administered two doses of the controlled substance to one resident during a medication pass and that the medication was not administered as prescribed by the physician.

A second resident was identified to have a medication order for an antidepressant and laxative to be administered on a regular scheduled basis.

During review of the medication incidents it was also identified that a Health Care Aide (HCA) discovered two pills in a medicine cup on the residents' bedside table.

After investigation by an RPN, it was determined that the medication on the bedside table was from a previous medication pass and that the second resident did not receive the medication as prescribed by the physician.

A third resident was identified to have a physician's order for a controlled substance to be administered on a regular scheduled basis.

During review of the medication error incidents it was identified that an RPN discovered that on two identified dates, the third resident did not receive the correct dose the controlled substance medication as prescribed by the physician.

In an interview with the ADOC, it was confirmed that the above three identified residents did not receive their medication as prescribed by the physician.

The licensee has failed to ensure that drugs are administered to resident #008, #009 and #010 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance o ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that one resident's written record was kept up to date at all times.

A progress note for one identified resident included that an assessment was completed with identification of injuries.

The progress note did not include the cause of the injuries or that the injuries were of unknown origin.

Another progress note for the same resident, stated that the resident had recent falls.

A third progress progress note for the resident titled "Follow-up fall."

Further review of the progress notes for the identified resident revealed the resident had experienced falls.

The ADOC shared with Inspector #144 that one RPN had told them (ADOC) that the resident experienced an undocumented fall on a specific date.

After the RQI was completed, the ADOC contacted Inspector #144 by telephone to report that the information the RPN had provided to them (ADOC) concerning the identified resident having an undocumented fall was incorrect.

The ADOC said that on a specified date the RPN had reported to them (ADOC) that the resident was found sitting in their wheelchair with a wound.

A progress note was then received by the inspector from the ADOC. The progress note revealed late entry documentation related to the circumstances surrounding the resident being found by nursing staff with a wound.

The ADOC confirmed by telephone that the above late entry was documented on the date of the telephone conversations between the ADOC and inspector and that the documentation related to the resident having recent falls was inaccurate and that staff were unaware of how the resident received the injuries.

The ADOC agreed that the clinical record for resident #012 was not kept up to date. [s. 231. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that one resident's written record was kept up to date at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to keep and display personal possessions, pictures and furnishings in his or her room, subject to safety requirements and other residents' rights.

A complaint intake identified that one resident was wanting additional furniture in their room to replace the furniture provided by the home.

The resident's family member stated to Inspector #725 that they had wanted to add an additional piece of furniture in the resident's room to place the television on to assist the resident with positioning and allow them to view the television in comfort.

The resident's family member further stated they had requested that a piece of furniture provided by the home be removed and that the manufacturer of the furniture they wanted to bring in suggested bolting it to the wall. The family member did not identify the individual that the request was made to within the home.

The ADOC confirmed the family brought in a piece of furniture and wanted to bring in one

additional piece to place the television on for positioning and comfort for the resident and then to allow for space, remove furniture provided by the home.

The ADOC confirmed that the family informed the home that if the furniture was bolted to the wall. it would be safe and not tip over.

The ADOC stated that this request was refused because it was a safety risk as the furniture could tip over and the home did not bolt items to the wall and would have nowhere to store the furniture provided by the home.

On observation of the home by Inspector #725, there were resident rooms observed with furniture resembling the piece the resident wanted in their room and a television hung on the wall in one resident room.

The ADOC was informed of the inspectors' observation.

Inspector #725 inquired about the difference between a television being bolted to the wall or a dresser. The ADOC responded bolting furniture to the wall would leave a bigger hole when the resident was discharged and there is no storage space for the piece of furniture provided by the home.

The homes policy titled Resident Belongings OPER-02-02-01 version NOVEMBER 2013 stated that "All resident belongings that are brought into the home must comply with the home's environmental and safety requirements."

When asked, ADOC #103 stated that there was no policy for environmental and safety requirements and other than the items listed in the resident belongings policy, the Administrator decided what was appropriate.

The licensee has failed to fully respect and promote the right of resident #014 to keep personal furnishings in their room. [s. 3. (1) 10.]

Issued on this 25th day of July, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.